DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To:	CUP Women Providers Managed Care Plans	**Memorandum No. 05-19 MAA** **Issued: April 5, 2005**
From:	Doug Porter, Assistant Secretary Medical Assistance Administration	**For Information Call:** (800) 562-6188
Subject:	**Chemical-Using Pregnant (CUP) Women Program: Changes to WAC and Billing Instructions**	

Effective for dates of service on and after May 1, 2005, the Medical Assistance Administration (MAA) is implementing policy changes for the Chemical Using Pregnant (CUP) Women Program, consistent with the changes to chapter 388-533 WAC.

What are the changes to the billing instructions?

MAA made the following changes to the *Chemical-Using Pregnant (CUP) Women Billing Instructions*, consistent with chapter 388-533 WAC:

- Clarified that Washington Medicaid Integration Partnership (WMIP) clients receive CUP services through their managed care plan;

- Deleted the eligibility requirement that a CUP client be assessed by an ADATSA assessment center only. Providers can now obtain a client's assessment from **any** chemical dependency professional;

- Deleted the requirement that a provider must obtain authorization from the MAA CUP Women program manager to allow the client to either:

  - ✓ Complete the original 26 day treatment plan; or
  - ✓ Begin a new 26 day treatment plan; and

- Updated some billing information according to HIPAA practices.

Where has MAA made the changes in the Billing Instructions?

Section	Change(s)
Important Contacts	Page ii - Updated or deleted outdated information on hard copy and electronic claims.
Client Eligibility	Page B.1 - Changed the first note box to eliminate the need for the chemical dependency assessment to be done by ADATSA. Page B.2 – Changed the first paragraph to clarify coverage for WMIP clients.
Coverage	Page C.1 - Deleted the following text to eliminate the need for the provider to obtain authorization from the MAA CUP Women program manager: ~~If a client leaves the program or is discharged and then returns, the provider must obtain authorization from the MAA CUP Women Program Manager to allow the client to either:~~ ~~• Complete the original 26-day treatment plan; or~~ ~~• Begin a new 26-day treatment plan.~~ Page C.2 – Adjusted wording under Transportation Services for clarity.
Provider Requirements	Page D.2 – Changed the language in the first bullet and first checkmark to eliminate the need for the chemical dependency assessment to be done by ADATSA.
Billing	Page E.2 – Eliminated the former number 4. that described outdated billing practices: ~~4. When billing:~~ ~~a) Hardcopy - Enter an "***N***" on your claim in *form locator 56*.~~ ~~b) Direct Entry - Request an ***S*** batch (inpatient non-DRG) when calling the Claims Control Unit at (360) 725-1950 for batch activation.~~ ~~c) Electronically - CUP Women services must be shown as follows:~~ ~~RECORD TYPE: 10~~ ~~RECORD NAME: Provider Data~~ ~~FIELD NUMBER: 2~~ ~~Indicate the type of batch equivalent to an ***S*** batch (inpatient non-DRG).~~

Section	Change(s)
How to Complete the UB-92 Claim Form	Page F.1 – Deleted outdated instructions for billing electronically: ~~When billing electronically, indicate claim type "S" for RCC.~~ ~~Medicare/Medicaid Crossover Claims cannot be billed electronically.~~ Page F.3 – Replaced outdated Revenue Code (~~168~~) with HIPAA revenue code (**129**).

How can I get MAA's provider issuances?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Table of Contents

Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs.
[WAC 388-502-0020(2)].

Who do I contact about payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
(800) 562-6188

Who do I contact if I'm interested in becoming a CUP Women program provider or have questions regarding CUP Women program policy?

Sue Green, Division of Alcohol and Substance Abuse (DASA)
(360) 438-8087

Todd Slettvet, MAA
(360) 725-1626

Where do I send my claims?

Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Who do I contact if I want to request an extended stay?

Todd Slettvet, MAA CUP Women Program Manager
Division of Program Support
Family Services Section
PO Box 45530
Olympia, WA 98504-5530
sletttd@dshs.wa.gov
(360) 725-1626

Where do I call/look if I have questions regarding…

Policy, payments, denials, or general questions regarding claims processing, or MAA Managed Care?

Provider Relations Unit
(800) 562-6188
http://maa.dshs.wa.gov/provrel

Private insurance or third-party liability, other than MAA Managed Care?

Coordination of Benefits Section
(800) 562-6136

Internet Billing (Electronic Claims Submission)?

EDI Gateway
http://www.acs-gcro.com/
Select *Medicaid*, then *Washington State*

All other HIPAA transactions
https://wamedweb.acs-inc.com/

To use HIPAA Transactions and/or EDI Gateway, enroll with ACS EDI Gateway Phone: (800) 833-2051 (toll free).

Client Eligibility

Who is eligible to receive CUP Women services?

[Refer to WAC 388-533-0710 (1)]

Adult and adolescent women are eligible for CUP Women services if they are:

- Pregnant;
- Have a medical need (including observation or monitoring);
- Have a substance abuse history and are screened "at risk";
- Have a current DSHS Medical Identification (ID) card (or have a pending application for one) with one of the program identifiers in the table below:

☞ **Note:** If a CUP woman is not currently a Medicaid client, initiate a Medicaid application within five days of admission. If a client has not had a chemical dependency assessment completed by a chemical dependency professional, contact the ADATSA Assessment Center DASA 24-Hour Help Line at 1-800-562-1240 (or the local number of the Center, if known) within the initial five-day period. If a client is not eligible for the CUP Women program, refer them to the local chemical dependency center, or call the 24-hour DASA Help Line for local resources at 1-800-562-1240.

Medical Identification Card Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP **CHIP**	Categorically Needy Program - Children's Health Insurance Program
CNP QMB	Categorically Needy Program - Qualified Medicare Beneficiary
LCP **MNP**	Limited Casualty Program – Medically Needy Program

☞ **Note:** If a client is not pregnant at admission, she is not eligible for CUP Women services. Clients with Medical ID cards with the three- or five-day DETOX ONLY section completed are NOT eligible for CUP Women services. Three- to five-day detoxification is funded at the county level and contains no medical component.
[Refer to WAC 388-533-0710(3)]

Are clients enrolled in an MAA managed care plan eligible for CUP Women services? [Refer to WAC 388-533-0710 (2)]

Yes! Clients enrolled in an MAA managed care plan, except for Washington Medicaid Integration Partnership clients, may receive CUP services outside their plan. CUP services must be billed directly to MAA and are paid through the fee-for-service system. If the client delivers during the 26-day stay, or during an approved extension, then delivery and newborn care must be billed fee-for-service. Coverage and billing guidelines found in these billing instructions apply to managed care clients as well as fee-for-service. Bill MAA directly.

Clients who are enrolled in managed care will have an "HMO" identifier in the HMO column on their DSHS Medical ID cards.

Coverage

What is covered? [Refer to WAC 388-533-0730 (1)-(3)]

The maximum length of treatment per inpatient stay that MAA will pay for is 26 days. Often, medical episodes, long-term substance abuse, resistance to treatment, or other factors slow treatment progression. An approval for extended days may be requested (see page C.4).

MAA pays for the following covered services provided to a pregnant client and her fetus under the CUP Women program:

- **Acute Detoxification/Medical Stabilization/Rehabilitation Services**

  ✓ **Primary Acute Detoxification/Medical Stabilization** - approximately 3-5 days.

  ✓ **Secondary Sub-Acute Detoxification/Medical Stabilization** - approximately 7-10 days.

  ✓ **Rehabilitation/Treatment** - remainder of stay may include the following:

  - Assessment for ongoing treatment/clean and sober housing;
  - Referrals and linkage to all providers and case managers;
  - Chemical dependency education;
  - Ongoing medical attention including obstetrical appointments;
  - Ultrasounds or medical services;
  - Methadone maintenance when appropriate;
  - Reintegration/reentry into the community;
  - Ongoing treatment if need assessed;
  - Referrals as appropriate;
  - Partial hospitalization/day treatment; and
  - Outpatient services.

  ✓ **Other Services** - In addition to the core services of detoxification, medical stabilization, and rehabilitation, other services **may** include, but are not limited to:

  - Medical nutrition therapy;
  - Childbirth preparation & delivery;

- Art and movement therapy;
- Drug education and awareness for family;
- Self-reliance education;
- Parenting education in the care of alcohol/drug-affected infants;
- Family dynamics education;
- Vocational counseling;
- Psychological counseling;
- Psychotherapy and group therapy;
- Life skills, including use of Medicaid transportation and First Steps childcare;
- Financial management;
- Household management;
- Physical appearance consultation; and
- Day Treatment - Outpatient Treatment.

☞ **Note:** In the event that needed services are not available on site, refer clients to applicable community services. In these situations, the client remains an inpatient and is not discharged and then re-admitted to the CUP Women program. Often a case manager or attendant escorts the client off-site or the service visit occurs at the hospital.

- **Transportation Services**

CUP Women services include the use of Medicaid-funded transportation to and from medical services while the woman is an inpatient at the CUP Women facility.

Clients sometimes travel to see an established provider and require an attendant away from the hospital. MAA's Transportation Services program has contracted brokers who cover the transportation of the client and an attendant.

For further information regarding MAA's Transportation Services program:

Access the Transportation Services website at:
http://maa.dshs.wa.gov/transportation

or call:
(800) 562-3022

Provider Requirements

Who is approved to provide CUP Women services?
[Refer to WAC 388-533-720 (1)]

MAA pays only those providers who:

- Have been approved by MAA to provide CUP Women program services;
- Have been certified as chemical dependency service providers by the Division of Alcohol & Substance Abuse (DASA) as described in Chapter 388-805 WAC;
- Meet hospital standards as prescribed by the Joint Commission on Accreditation of Healthcare Organization (JCACHO).
- Meet the general provider requirements in Chapter 388-502 WAC; and
- Are not licensed as an Institution for Mental Disease (IMD) under Centers for Medicare and Medicaid (CMS) criteria.

Program Administration **[Refer to WAC 388-533-720 (2)]**

Chemical-using pregnant (CUP) women program service providers must:

- Report any changes in their certification, level of care, or program operation to the MAA CUP Women Program Manager (see *Important Contacts* section). Prior to providing CUP Women services, you must submit your program application to, and receive approval from, DASA and MAA;
- Have written policies and procedures that include a working statement describing the purpose and methods of treatment for chemical-using/abusing pregnant women;
- Provide guidelines and resources for current medical treatment methods by specific drug and or alcohol type;
- Have linkages with state and community providers to ensure a working knowledge exists of current medical and substance abuse resources; and

- Ensure that a chemical dependency assessment of the client has been completed:

  ✓ By a chemical dependency professional as defined in chapter 246-811 WAC;

  ✓ Using the latest criteria of the American Society of Addiction Medicine (ASAM) which may include:

    - Pregnancy, post-pregnancy, and parenting status;
    - Number of children, custody status, residence, and visitation schedule;
    - History of Child Protective Service intervention;
    - History of death or loss of children;
    - Childcare needs;
    - Family Planning practices and needs;
    - Suicidal/homicidal ideation;
    - Domestic violence history;
    - Sexual assault history;
    - Ongoing mental health needs;
    - Current and past history of chemical use during pregnancy;
    - Previous pregnancy prenatal care;
    - Relationship addiction;
    - Family dynamics;
    - Family reunification plans;
    - Living situation/housing;
    - Legal issues; and
    - Eating disorders; and

  ✓ No earlier than six months before, and no later than five days after, the client's admission to the CUP Women program.

Notifying Clients of Their Rights (Advance Directives)

(42 CFR, Subpart I)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Billing

How do I bill for CUP Women services?

Use the UB-92 claim form to bill the hospital-based intensive CUP Women services provided to the client. Follow these guidelines when billing:

1. In order to facilitate processing of claims under this program, **MAA has established a daily room and board revenue code. The revenue code is 129.** This revenue code is used for the entire CUP stay. You must indicate this revenue code *in form locator 51* of the UB-92. MAA reimburses for daily room rate charges *only* with this revenue code.

   ☞ **Note:** For stays that exceed 26 days, bill:

   - Hardcopy by attaching a copy of the MAA written approval for extended stay with the claim;
   - Electronically by entering the date of approval and dates of service approved in the ***Remarks*** Field.

2. All claims for CUP Women services need a primary diagnosis code related to pregnancy and a secondary diagnosis code related to alcohol or drug abuse. You must use the following ICD-9-CM diagnosis codes when billing MAA for these services:

   a) Primary diagnosis: 648.33 (drug dependency - antepartum) or 648.34 (drug dependency – postpartum); and
   b) Secondary diagnosis: choose the appropriate alcohol or drug abuse diagnosis code(s) from among codes 303 through 304.9.

3. For any other (ancillary) revenue codes, refer to MAA's Inpatient Hospital Billing Instructions.

4. When inpatient hospital acute detoxification and medical stabilization services are 24 hours or less, you must bill these services as a short stay on an outpatient claim.

   Inpatient hospitals should use their regular provider number and follow MAA's *Inpatient Hospital Billing Instructions* to bill non-DRG claims. **Do not** use the provider number issued for three-day or five-day detoxification programs, as these are different programs and funded through the county.

   MAA reimburses the hospital a percentage of **allowed charges** for these services. CUP Women services are exempt from DRG reimbursement methodology. Reimbursement is based on the hospital's ratio of cost-to-charges (RCC) rate and usual and customary fee.

How to Complete the UB-92 Claim Form

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).

If a client is not eligible for the entire hospital stay, bill only dates of service for which the client is eligible.

☞ **Note:** Shaded fields are required fields **only** for UB-92 Medicare/Medicaid Crossover Claims."

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No.** - This is a 20-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** - Indicate type of bill using 3 digits as follows:

Type of Facility (first digit)
1 = Hospital
Bill Classification (second digit)
1 = Inpatient

Frequency (third digit)
1 = Admit through discharge claim
2 = Interim - First Claim
3 = Interim - Continuing Claim
4 = Interim - Last Claim
5 = Late Charge(s) Only Claim

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's Medical Identification card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birthdate.

15. **Patient's Sex** - Enter the client's sex.

17. **Admission Date** - Enter the date of admission (MMDDYY).

18. **Admission Hour** - The hour during which the patient was admitted for inpatient care. Use the appropriate two-digit code listed in the next column.

Code	Time: A.M.	Code	Time: P.M.
00	12:00 - 12:59 (Midnight)	12	12:00 - 12:59 (Noon)
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

19. **Type of Admission** - Enter type of admission.

1 = Emergent
2 = Urgent
3 = Elective
4 = Newborn

20. **Source of Admission** - Enter source of admission.

1 = Physician Referral
2 = Clinic Referral
3 = HMO Referral
4 = Transfer from a hospital
5 = Transfer from a nursing facility
6 = Transfer from another health care facility
7 = Emergency Room
8 = Court/Law Enforcement
9 = Information Not Available

21. **Discharge Hour** - The hour during which the patient was discharged from care.

22. **Patient Status** - Enter one of the following codes to represent the disposition of the patient at discharge:

01 = Discharge to home or self care (routine discharge)
02 = Transferred to another short-term general hospital
03 = Discharged/transferred to nursing facility (SNF)
04 = Discharged/transferred to nursing facility (ICF)
05 = Transferred to an exempt unit or hospital
06 = Discharged/transferred to home under the care of an organized home health service organization
07 = Left against medical advice
20 = Expired
30 = Still patient

Medicare Crossover claims only

39-41. Value Codes and Amounts - Enter one of the following, as appropriate:

45 = Accident Hour (use the chart listed next to form locator 18 for admission hours)

80 = Newborn's birth weight in gram

39A: **Deductible**: Enter the code *A1*, and the deductible as reported on your EOMB.

39D: **ENC Rate**: Enter Med's ENC rate as reported on the EOMB.

40A: **Coinsurance**: Enter the code *A2*, and the coinsurance as reported on your EOMB.

40D: **Encounter Units**: Enter the encounter units Medicare paid, as reported on EOMB.

41A: **Medicare Payment**: Enter the payment by Medicare as reported on your EOMB.

41D: **Medicare's Process Date**: Enter the date that Medicare processed the claim, as reported on your EOMB in numerals only (*MMDDYY*).

42. **Revenue Code** - Enter **129**. Enter *001* for total charges on line 23 of this form locator on the final page.

43. **Revenue or Procedure Description** - Enter a narrative description of the related revenue included on this bill. Abbreviations may be used. Enter the description *total charges* on line 23 of this form locator on the final page.

44. **HCPCS/Rates** - Enter the accommodation rate for inpatient bills.

46. **Units of Service** - Enter the quantity of services listed by revenue or procedure code(s).

47. **Total Charges** - Enter charges pertaining to the related revenue code(s) or procedure code(s). Enter the total of this column as the last detail on line 23 of this form locator on the last page.

48. **Noncovered** - Any noncovered charges pertaining to detail revenue or procedure codes should be entered here. (These services will be *categorically denied*.) Enter the total of this column as the last detail on line 23 of this form locator on the last page.

50. **Payer Identification: A/B/C** - Enter if all health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of additional insurance (e.g., Medicare, Aetna, etc.), if applicable.
50C: Enter the name of additional insurance, if applicable.

51. **Provider Number** - Enter the hospital provider number issued to you by DPS. This is the seven-digit provider number beginning with a *3* that appears on your Remittance and Status Report.

Medicare Crossover claims only

51A: Enter the seven-digit Medicaid provider number that appears on your Remittance and Status Report.

51B: Enter your Medicare provider number.

54. **Prior Payments: A/B/C** - Enter the amount due or received from all insurances. **Do not include Spenddown or EMER here. See form locator 57.**

54A: Enter any prior payments from payor listed in form locator 50A.
54B: Enter any prior payments from payor listed in form locator 50B.
54C: Enter any prior payments from payor listed in form locator 50C.

55. **Estimated Amount Due: A/B/C** –

55A: Enter the estimated amount due from MAA minus any amounts listed in form locators 48, 54, and 57.
55B: Not required to be filled in.
55C: Not required to be filled in.

57. **Due from Patient (Patient Liability)** Enter the total patient liability amount which includes Spenddown and/or EMER.

Refer to the bottom of the client's *Approval for MI EMER/Spenddown Met* Letter issued by the local DSHS Community Service Office for the Spenddown/EMER amount.

58. **Insured's Name: A/B/C** - If other insurance benefits are available and coverage is under another name, enter the insured's name.

60. **Cert-SSN-HIC-ID NO.** - Enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Identification card. This information is obtained from the client's current monthly Medical Identification card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d. An alpha or numeric character (tie breaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered